REPORT OF INJURY

(AR 27-40)

PRIVACY ACT STATEMENT

Authority: 5 USC; 10 USC 3012; 42 USC 2651; Executive Order 9397. **Purpose:** To provide information necessary to enable the Government to recover the reasonable value of medical care furnished at its expense as the result of injuries received from tort-feasors. **Routine Use:** (1) Identify injured party and nature of injuries, (2) Identify other persons involved, including witnesses, (3) Determine the circumstances of incidents which give rise to personnel injuries, (4) Determine the insurance coverage and places of medical treatments, and (5) Social security number will be used for identification purposes when requesting information from other agencies. **Disclosure:** Mandatory disclosure. Failure to provide requested information will result in withholding of medical records pertaining to medical history, diagnoses, findings, and treatment from the injured party or his/her representatives.

INSTRUCTIONS FOR COMPLETING REPORT OF INJURY FORM

- Pursuant to Army Regulations 27-40 and 40-16, Judge Advocate personnel and Medical Department personnel are required to obtain information concerning the circumstances surrounding the injuries of persons receiving medical care at Government expense. These regulations apply equally to active or retired personnel and their dependents.
- Please fill out this form completely and answer all questions. If answer is unknown or not applicable, so state. Use the remarks section or additional sheets of paper to amplify your answers. In cases involving motor vehicles, complete all sections and make a detailed diagram of the accident scene on page 4. Show the direction of travel of each vehicle and points of impact. Designate your vehicle as No. 1 and the other vehicle(s) as No. 2 (and No. 3).
- If the injuries did not result from a motor vehicle incident, you may skip Sections II and III.
- *Notify your own insurance carrier even though the injured party was a pedestrian, a passenger in another vehicle, vicdtim of a "hit and run" incident, or if it was a one vehicle accident. Failure to do so may jeopardize any right of recovery you have or the rights of the Government.*

SECTION I. INJURED PARTY

NAME	**GRADE**	**SSN**

ORGANIZATION	**TELEPHONE**
PRESENT RESIDENCE ADDRESS	**TELEPHONE**
PERMANENT HOME ADDRESS	**TELEPHONE**
DATE OF BIRTH	**Status** ☐ **Active** ☐ **Retired** ☐ **Dependent** ☐ If active, give estimate of date of transfer or separation

IF THE INJURED PARTY WAS DEPENDENT, COMPLETE THE FOLLOWING CONCERNING SPONSOR.

NAME	**GRADE**	**SSN**

ORGANIZATION	**TELEPHONE**
PRESENT RESIDENCE ADDRESS	**TELEPHONE**
PERMANENT HOME ADDRESS	**TELEPHONE**
If on active duty, give estimate of date of transfer or separation	**Status -** Active ☐ Retired ☐

SECTION II – DETAILS

DATE & TIME (*hours)* OF INCIDENT	**LOCATION (street, city, county, state)**

If you were in a vehicle, were you ☐ **driver** ☐ **passenger** ☐ **owner**

NAME OF DRIVER	**ADDRESS**
NAME OF OWNER	**ADDRESS**

Was there any cost sharing arrangement between the owner and driver, or any passenger? ☐ **Yes** ☐ **No**

If Yes, give complete details.

DESCRIPTON OF VEHICLE	MAKE	MODEL	LICENSE NO.	STATE	MILITARY DECAL NO.

MECHANICAL DEFECTS ☐ Yes ☐ No If yes, specify

OTHER PASSENGERS IN THE VEHICLES WHICH YOU WERE IN.
If they were military, give home address, organization, and SSN. If they were military dependents, so state.

NAME	ADDRESS OR ORGANZATION	INJURED
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SECTION III – OTHER VEHICLE

NAME OF DRIVER	**ADDRESS**
NAME OF OWNER	**ADDRESS**

DESCRIPTON OF VEHICLE	MAKE	MODEL	LICENSE NO.	STATE	MILITARY DECAL NO.

MECHANICAL DEFECTS ☐ Yes ☐ No If yes, specify

PASSENGERS IN OTHER VEHCILE (Furnish the same data as above)

NAME	ADDRESS OR ORGANZATION	INJURED
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SECTION IV – INSURANCE DATA

1. Give name and address of any hospitalization insurance you may carry.

2. Give name and address of insurance company for the vehicle you were in.

- **Does the policy have medical payments (Coverage C)? ☐ Yes ☐ No**
- **Does the policy have personal injury protection coverage? ☐ Yes ☐ No**
- **Does the policy have uninsured motorists coverage? ☐ Yes ☐ No**

Policy No.	EXPIRATION DATE:

3. Give name and address of insurance company for the any vehicle you own.

- **Does the policy have medical payments (Coverage C)? ☐ Yes ☐ No**
- **Does the policy have personal injury protection coverage? ☐ Yes ☐ No**
- **Does the policy have uninsured motorists coverage? ☐ Yes ☐ No**

4. Give name and address of insurance company for the other vehicle.

5. If an insurance adjuster has contacted you, please furnish name and address:

- **Did he/she represent your company (☐ Yes ☐ No) or the company insuring the car in which the car in which you were riding (☐ Yes ☐ No) or the company insuring the other vehicle (☐ Yes ☐ No)**
- **If you have given a written statement to anyone concerning this accident, please furnish a copy or advise to who it was given**
- **Have you received any settlement for your personal injuries? ☐ Yes ☐ No**
- **If so, state amount have you signed a release? ☐ Yes ☐ No**

6. If you have consulted an attorney in connection with this accident, give his/her name and address.

- Do you want medical records of the injured party released to this attorney? ☐ **Yes** ☐ **No**